General

Guideline Title

Organ donation for transplantation: improving donor identification and consent rates for deceased organ donation.

Bibliographic Source(s)

National Institute for Health and Clinical Excellence (NICE). Organ donation for transplantation: improving donor identification and consent rates for deceased organ donation. London (UK): National Institute for Health and Clinical Excellence (NICE); 2011 Dec. 26 p. (Clinical guideline; no. 135).

Guideline Status

This is the current release of the guideline.

Recommendations

Major Recommendations

Note from the National Guideline Clearinghouse (NGC): This guideline was developed by the Centre for Clinical Practice at the National Institute for Health and Clinical Excellence (NICE). See the Availability of Companion Documents field for the full version of this guidance.

Identifying Patients Who Are Potential Donors

Organ donation should be considered as a usual part of 'end-of-life care' planning.

Identify all patients who are potentially suitable donors as early as possible, through a systematic approach. While recognising that clinical situations vary, identification should be based on either of the following criteria:

- Defined clinical trigger factors in patients* who have had a catastrophic brain injury, namely:
  - The absence of one or more cranial nerve reflexes and
  - A Glasgow Coma Scale (GCS) score of 4 or less that is not explained by sedation unless there is a clear reason why the above clinical triggers are not met (for example because of sedation) and/or a decision has been made to perform brainstem death tests, whichever is the earlier

*It is recognised that a proportion of the patients who are identified by these clinical triggers will survive.

- The intention to withdraw life-sustaining treatment in patients with a life-threatening or life-limiting condition which will, or is expected to, result in circulatory death.

The healthcare team caring for the patient should initiate discussions about potential organ donation with the specialist nurse for organ donation at

the time the criteria in the recommendation above are met.

Patients Who Have Capacity

In circumstances where a patient has the capacity to make their own decisions, obtain their views on, and consent to, organ donation.*

*If the potential donor is under 16, healthcare professionals should follow the guidelines in Seeking consent: working with children .

Assessing Best Interests

If a patient lacks capacity to make decisions about their end-of life-care, seek to establish whether taking steps, before death, to facilitate organ donation would be in the best interests of the patient.

While assessing the patient's best interests clinically stabilise the patient in an appropriate critical care setting while the assessment for donation is performed – for example, an adult intensive care unit or in discussion with a regional paediatric intensive care unit (see the last recommendation in this section).

Provided that delay is in the patient's overall best interests, life-sustaining treatments should not be withdrawn or limited until the patient's wishes around organ donation have been explored and the clinical potential for the patient to donate has been assessed in accordance with legal and professional guidance.*,**

*Donation After Circulatory Death (DCD) consensus meeting report, available from www.ics.ac.uk/intensive_care_professional/standards_and_guidelines/dcd

**General Medical Council (GMC) guidance on treatment and care towards the end of life

In assessing a patient's best interests, consider:

- The patient's known wishes and feelings, in particular any advance statement or registration on the National Health Service (NHS) organ donor register† but also any views expressed by the patient to those close to the patient
- The beliefs or values that would be likely to influence the patient's decision if they had the capacity to make it
- Any other factors they would be likely to consider if they were able to do so
- The views of the patient's family, friends and anyone involved in their care as appropriate as to what would be in the patient's best interests; and
- Anyone named by the patient to be consulted about such decisions.

†Available from www.uktransplant.org.uk or www.organdonation.nhs.uk

Seeking Consent to Organ Donation

If a patient lacks the capacity to consent to organ donation seek to establish the patient's prior consent by:

- Referring to an advance statement if available
- Establishing whether the patient has registered and recorded their consent to donate on the NHS organ donor register* and
- Exploring with those close to the patient whether the patient had expressed any views about organ donation

*General Medical Council (GMC) guidance on treatment and care towards the end of life

If the patient's prior consent has not already been ascertained, and in the absence of a person or persons having been appointed as nominated representative(s), consent for organ donation should be sought from those in a qualifying relationship with the patient. Where a nominated representative has been appointed and the person had not already made a decision about donation prior to their death, then consent should be sought after death from the said nominated representative(s).

Approach to Those Close to the Patient

The Multidisciplinary Team (MDT)

An MDT should be responsible for planning the approach and discussing organ donation with those close to the patient.

The MDT should include:

- The medical and nursing staff involved in the care of the patient, led throughout the process by an identifiable consultant
- The specialist nurse for organ donation
- Local faith representative(s) where relevant

Whenever possible, continuity of care should be provided by team members who have been directly involved in caring for the patient.

The MDT involved in the initial approach should have the necessary skills and knowledge to provide to those close to the patient appropriate support and accurate information about organ donation (see the recommendation about the MDT and the skills and competencies required in the section entitled 'Organisation of the Identification, Referral and Consent Processes' below).

Discussions in All Cases

Before approaching those close to the patient:

- Identify a patient's potential for donation in consultation with the specialist nurse for organ donation.
- Check the NHS organ donor register and any advance statements or Lasting Power of Attorney for health and welfare.
- Clarify coronial, legal and safeguarding issues.

Before approaching those close to the patient, try to seek information on all of the following:

- Knowledge of the clinical history of the patient who is a potential donor
- Identification of key family members
- Assessment of whether family support is required – for example faith representative, family liaison officer, bereavement service, trained interpreter, advocate
- Identification of other key family issues
- Identification of cultural and religious issues that may have an impact on consent

Approach those close to the patient in a setting suitable for private and compassionate discussion.

Every approach to those close to the patient should be planned with the MDT and at a time that suits the family's circumstances.

In all cases those close to the patient should be approached in a professional, compassionate and caring manner and given sufficient time to consider the information.

Discussions about organ donation with those close to the patient should only take place when it has been clearly established that they understand that death is inevitable or has occurred.

When approaching those close to the patient:

- Discuss with them that donation is a usual part of the end-of-life care.
- Use open-ended questions – for example 'how do you think your relative would feel about organ donation?'
- Use positive ways to describe organ donation, especially when patients are on the NHS organ donor register or they have expressed a wish to donate during their lifetime – for example 'by becoming a donor your relative has a chance to save and transform the lives of many others'.
- Avoid the use of apologetic or negative language (for example 'I am asking you because it is policy' or 'I am sorry to have to ask you').

The healthcare team providing care for the patient should provide those close to the patient who is a potential donor with the following, as appropriate:

- Assurance that the primary focus is on the care and dignity of the patient (whether the donation occurs or not)
- Explicit confirmation and reassurance that the standard of care received will be the same whether they consider giving consent for organ donation or not
- The rationale behind the decision to withdraw or withhold life-sustaining treatment and how the timing will be coordinated to support organ donation
- A clear explanation of, and information on:
    - The process of organ donation and retrieval, including post-retrieval arrangements
    - What interventions may be required between consent and organ retrieval
    - Where and when organ retrieval is likely to occur
    - How current legislation applies to their situation,* including the status of being on the NHS organ donor register or any advance

statement
    - How the requirements for coronial referral apply to their situation
- Consent documentation
- Reasons why organ donation may not take place, even if consent is granted

*Mental Capacity Act (2005) and Human Tissue Act (2004)

Allow sufficient time for those close to the patient to understand the inevitability of the death or anticipated death and to spend time with the patient.

Discuss withdrawal of life-sustaining treatment or neurological death before, and at a different time from, discussing organ donation unless those close to the patient initiate these discussions in the same conversation.

For discussions where circulatory death is anticipated, provide a clear explanation on:

- What end-of-life care involves and where it will take place – for example, theatre, critical care department
- How death is confirmed and what happens next
- What happens if death does not occur within a defined time period

For discussions where neurological death is anticipated, provide a clear explanation on:

- How death is diagnosed using neurological criteria
- How this is confirmed and what happens next

Organisation of the Identification, Referral and Consent Processes

Each hospital should have a policy and protocol that is consistent with these recommendations for identifying patients who are potential donors and managing the consent process.

Each hospital should identify a clinical team to ensure the development, implementation and regular review of their policies.

Adult and paediatric intensive care units should have a named lead consultant with responsibility for organ donation.

The MDT involved in the identification, referral to specialist nurse for organ donation, and consent should have the specialist skills and competencies necessary to deliver the recommended process for organ donation outlined in this guideline.

The skills and competencies required of the individual members of the team will depend on their role in the process. However, all healthcare professionals involved in identification, referral to specialist nurse for organ donation, and consent processes should:

- Have knowledge of the basic principles and the relative benefits of, donation after circulatory death (DCD) versus donation after brainstem death (DBD)
- Understand the principles of the diagnosis of death using neurological or cardiorespiratory criteria and how this relates to the organ donation process
- Be able to explain neurological death clearly to families
- Understand the use of clinical triggers to identify patients who may be potential organ donors
- Understand the processes, policies and protocols relating to donor management
- Adhere to relevant professional standards of practice regarding organ donation and end-of-life care

Consultant staff should have specific knowledge and skills in:

- The law surrounding organ donation
- Medical ethics as applied to organ donation
- The diagnosis and confirmation of death using neurological or cardiorespiratory criteria
- The greater potential for transplantation of organs retrieved from DBD donors compared with organs from DCD donors
- Legally and ethically appropriate clinical techniques to secure physiological optimisation in patients who are potential organ donors
- Communication skills and knowledge necessary to improve consent ratios for organ donation

Clinical Algorithm(s)

The recommendations from this guideline have been incorporated into a National Institute for Health and Clinical Excellence (NICE) Pathway .

Scope

Disease/Condition(s)

Death with potential organ donation, including:

- Donation after brain-stem death (DBD)
- Donation after cardiac death (DCD)

Guideline Category

Counseling

Evaluation

Clinical Specialty

Cardiology

Critical Care

Family Practice

Internal Medicine

Neurology

Nursing

Pediatrics

Surgery

Intended Users

Advanced Practice Nurses

Hospitals

Nurses

Other

Physician Assistants

Physicians

Psychologists/Non-physician Behavioral Health Clinicians

Guideline Objective(s)

- To produce a clinical guideline on improving donor identification and consent rates for cadaveric organ donation
- To improve consent rates by making recommendations based on evidence where it is available, on the structures and processes of

identifying potential donors and the approach for consent

Target Population

- Families, relatives and legal guardians of potential donation after brain-stem death (DBD) donors (adults and children) in National Health Service (NHS) setting
- Families, relatives and legal guardians of potential donation after cardiac death (DCD) donors (adults and children) in NHS settings

Note: Within this population, the following groups have been identified as needing special consideration:

People from black and minority ethnic groups
People with differing religious beliefs

Note: Groups involved in giving consent on organ donation other than those described above are not covered in this guideline.

Interventions and Practices Considered

1. Identification of all patients who are potentially suitable donors as early as possible
2. Obtaining views and consent to organ donation in patients who have the capacity
3. Assessing best interests of patient if they lack capacity to make decisions about end-of-life care
4. Clinically stabilising the patient in an appropriate critical care setting while the assessment for donation is performed
5. Seeking consent to organ donation
    - Patient's advance statement
    - National Health Service (NHS) organ donor register
    - Views on organ donation expressed by patient to those close to them
6. Multidisciplinary team (MDT) approach to discussing organ donation with those close to the patient
7. Approaching those close to the patient:
    - Ensuring a setting suitable for private and compassionate discussion
    - Planning meetings with the MDT
    - Timing of approaches
    - Information to seek prior to approaching (clinical history, key family members, need for family support, family, cultural or religious issues)
    - Discussing donation as usual part of end-of-life care, in a positive manner, avoiding negative or apologetic language
8. Reassuring those close to patient regarding primary focus, standard of care, dignity of the patient and rationale for withdrawal of care
9. Providing clear information and explanation on process, interventions and requirements of organ donation
10. Allowing those close to patient to spend time with patient prior to death
11. Providing explanations of neurological and circulatory death
12. Development of a clinical team, protocols, and policies by each hospital for the organization, referral and consent processes
13. Ensuring individual members of the clinical team have the skills and competencies required (including legal, medical and ethical areas)

Major Outcomes Considered

- Rates of identification of potential donors
- Rates of consent for donation
- Rates of organ donation for transplantation
- Rates of successful transplants
- Rates of viable organs retrieved
- Rates of family, relatives and legal guardians refusal
- Families, relatives and legal guardians' experience of the structures and processes for organ donation

Methodology

Methods Used to Collect/Select the Evidence

Searches of Electronic Databases

Description of Methods Used to Collect/Select the Evidence

Note from the National Guideline Clearinghouse (NGC): This guideline was developed by the Centre for Clinical Practice at the National Institute for Health and Clinical Excellence (NICE). See the Availability of Companion Documents field for the full version of this guidance.

Search Strategies

Medline search strategies for the Organ Donation guideline

Scoping Searches

Scoping searches were undertaken in March 2010 using the following websites and databases (listed in alphabetical order); browsing or simple search strategies were employed. The search results were used to provide information for scope development and project planning.

Guidance/Guidelines	Systematic Reviews/Economic Evaluations
British Medical Association Canadian Medical Association Infobase Clinical Knowledge Summaries Department of Health Donor Family Network European Transplant Coordinators Organisation General Medical Council Guidelines International Network (GIN) Human Tissue Authority National Guideline Clearinghouse (US) National Health and Medical Research Council (Australia) National Institute for Health and Clinical Excellence (NICE) – guidance published & in development National Institute for Health and Clinical Excellence (NICE) – topic selection National Health Service (NHS) Blood and Transplant NHS Confederation NHS Evidence New Zealand Guidelines Group Royal College of General Practitioners Royal College of Pathologists Scottish Intercollegiate Guidelines Network (SIGN)	Clinical Evidence Cochrane Database of Systematic Reviews (CDSR) Database of Abstracts of Reviews of Effects (DARE) Health Economic Evaluations Database (HEED) Health Technology Assessment (HTA) Database NHS Economic Evaluation Database (NHS EED) NHS R&D Service Delivery and Organisation (NHS SDO) Programme National Institute for Health Research (NIHR) Health Technology Assessment Programme TRIP Database

Main Searches

The following sources were searched for the topics presented in the full version of the guideline.

- Cochrane Database of Systematic Reviews – CDSR (Wiley)
- Cochrane Central Register of Controlled Trials – CENTRAL (Wiley)
- Database of Abstracts of Reviews of Effects – DARE (CRD)
- Health Technology Assessment Database – HTA (CRD)
- CINAHL (NHS Evidence)
- EMBASE (Ovid)
- MEDLINE (Ovid)
- MEDLINE In-Process (Ovid)

The MEDLINE search strategies are presented in Appendix A of the full version of the guideline. They were translated for use in all of the other databases. See Appendix B of the full version of the guideline for the retrieval based on each research question.

A total of 3465 articles were found by systematic searches for review questions 1 to 4 (see below). Full text articles were ordered for 311 articles based on the title and abstract. Sixty-one papers met the eligibility criteria (for review protocol and inclusion and exclusion criteria, see Appendix C in the full version of the guideline). Although searches were undertaken for review question 5, the technical team and the Guideline Development Group (GDG) considered that evidence already reviewed and included for review questions 1 to 4 would adequately inform evidence-based recommendations on the skills and competencies needed by healthcare professionals. For example, where a lack of knowledge or skills was identified for healthcare professionals as part of review question 2, a recommendation was made that healthcare professionals should have those skills and knowledge in order to implement the other recommendations made in the guideline.

Review Questions

Review question 1: What structures and processes including timing for referral and criteria for consideration are appropriate and effective for identifying potential donation after brainstem death (DBD) and donation after circulatory death (DCD) donors?

Review question 2: What structures and processes are appropriate and effective for obtaining consent from families, relatives and legal guardians of potential DBD and DCD donors?

Review question 3: When is the optimal time for approaching the families, relatives and legal guardians of potential DBD and DCD donors for consent?

Review question 4: How should the care pathway of deceased organ donation should be coordinated to improve potential donors giving consent?

Review question 5: What key skills and competencies are important for healthcare professionals to improve the structures and processes for identifying potential DBD and DCD, to improve structures and processes for obtaining consent, and to effectively coordinate the care pathway from identification to obtaining consent?

Health Economic Modelling

The decision problem for this guideline was to examine the value of increasing consent and conversion rates. It was not to examine the value of transplantation. A search for literature did not find any relevant papers that addressed this particular economic issue. Papers were identified that examined the cost effectiveness of different allocation processes and the cost effectiveness of certain transplantations.

Number of Source Documents

Total Number of Studies Included

See the Description of Methods Used to Collect/Select the Evidence field for the list of review questions.

Review question 1: 14

Review question 2: 33

Review question 3: 10

Review question 4: 4

Review question 5: No additional studies

Methods Used to Assess the Quality and Strength of the Evidence

Expert Consensus (Committee)

Weighting According to a Rating Scheme (Scheme Given)

Rating Scheme for the Strength of the Evidence

Overall Quality of Outcome Evidence in Grading of Recommendations Assessment, Development and Evaluation

Level	Description
High	Further research is very unlikely to change confidence in the estimate of effect
Moderate	Further research is likely to have an important impact on confidence in the estimate of effect and may change the estimate
Low	Very likely to have an important impact on confidence in the estimate of effect and is likely to change the estimate
Very low	Any estimate of effect is very uncertain

Methods Used to Analyze the Evidence

Systematic Review with Evidence Tables

Description of the Methods Used to Analyze the Evidence

Note from the National Guideline Clearinghouse (NGC): This guideline was developed by the Centre for Clinical Practice at the National Institute for Health and Clinical Excellence (NICE). See the Availability of Companion Documents field for the full version of this guidance.

Although systematic reviews were undertaken for each of the review questions (except review question 5), the evidence review provided a summary of the whole evidence-base used for this guideline. The reviews for each question can be seen separately in Appendix D of the full version of the guideline. However, when drafting the evidence statements and recommendations, it became clear that the evidence reviewed often covered more than one area of interest (that is, the search strategies used were not able to be specific enough to separate out the detailed components of the process that were of interest); therefore the process of identifying the evidence and drafting recommendations was iterative and reflective.

Grading of Recommendations, Assessment, Development and Evaluation (GRADE) assessment was adapted, and the following variables were considered: limitations, inconsistency, and indirectness. Imprecision was rated as not relevant for some areas because it did not apply to the type of evidence considered (for example, qualitative studies). Summary GRADE tables are presented in the full version of the guideline. For full GRADE profiles, see Appendix D of the full version of the guideline.

Health Economic Modelling

The analysis examined the effect of reducing the waiting time for organ transplantation. It was not possible to conduct an analysis that included all transplantations because of the lack of readily available data on all solid organ transplants. However, analysis could be done examining the effect of reduced waiting times on kidney transplantation. This is made possible because of the significant amount of data available on kidney transplantation including graft and overall survival estimates, costs of alternatives to transplantations (dialysis), waiting times and the ability to use a model developed for another short clinical guideline on peritoneal dialysis.

Methods Used to Formulate the Recommendations

Expert Consensus

Description of Methods Used to Formulate the Recommendations

Note from the National Guideline Clearinghouse (NGC): This guideline was developed by the Centre for Clinical Practice at the National Institute for Health and Clinical Excellence (NICE). See the Availability of Companion Documents field for the full version of this guidance.

Forming and Running the Short Clinical Guideline Development Group (GDG)

Each short clinical guideline is developed by a unique GDG consisting of 10–12 members, supported by the Short Clinical Guidelines Team. Each GDG has a Chair, healthcare professional members and a minimum of two patient and carer members. Co-opted expert advisers are recruited, as appropriate. A Clinical Adviser, who has specific content expertise and additional responsibilities, may also be appointed depending on the topic. Recruitment of the GDG Chair and members is carried out in accordance with NICE's policy.

The GDG makes its decisions using the best available evidence presented to it at GDG meetings by the Short Clinical Guidelines Team. The use of formal consensus methods within the GDG will be considered on a case-by-case basis.

Developing Review Questions

A short clinical guideline has a narrow scope and covers only part of a care pathway. It addresses a maximum of three subject areas covering clinical management. This will result in a small number of key clinical issues. These are broken down into a defined number of review questions — usually one or two per clinical management area. The exact number will be dictated by the size of the short clinical guideline remit and the amount of development time available.

Creating Guideline Recommendations

Explicit methods of linking the evidence to recommendations are used for short clinical guidelines if the topic is suitable. This involves using the Grading of Recommendations Assessment, Development and Evaluation (GRADE) approach.

Research recommendations are formulated for short clinical guidelines. Their number is dependent on the size of the short clinical guideline remit and the amount of development time available.

Writing the Guideline

There are usually three versions of short clinical guidelines:

- The full guideline – all the recommendations, details of how they were developed and summaries of the evidence they are based on
- The quick reference guide – a summary of the recommendations for healthcare professionals
- 'Understanding NICE guidance' – a summary for patients and carers

The full guideline is written by the Short Clinical Guidelines Team, following the principles in chapters 9 and 10 of 'The guidelines manual' (see the Availability of Companion Documents field).

Rating Scheme for the Strength of the Recommendations

Not applicable

Cost Analysis

The appendix on health economics for peritoneal dialysis (from the NICE guideline Peritoneal dialysis in the treatment of stage 5 chronic kidney disease) contains data on the clinical and cost effectiveness for other renal replacement therapies. Data on transplantation came from the National Health Service (NHS) Blood and Transplant (NHSBT) report 2009, the health technology assessment on kidney perfusion machines and NHS reference costs. A sensitivity analysis was conducted where the waiting time for kidney transplantation was varied from the current waiting time of 3.04 years to 6 months, which was achieved in Spain and is often considered to represent an optimum situation. Table 1 in the full version of the guideline document outlines the results of various waiting times for kidney transplants and the corresponding cost-effectiveness results.

The analysis indicates that reducing the waiting time for kidney transplant is cost effective. As waiting times fall, this reduction in waiting time becomes even more cost effective. This is the case even when factoring in the cost of more transplantations. See the full version of the original guideline for the limitations of this analysis.

Summary

Health economic analysis indicates that reducing the waiting list for organ donation is of considerable value to the NHS. The size of this reduction therefore supports the use of potentially expensive interventions or increased training requirements. So:

- Increasing the identification of potential organ donors would be cost effective.
- Increased use of staff to facilitate consent is cost effective.
- Training for the multidisciplinary group (MDT) to improve consent will be cost effective.

Method of Guideline Validation

External Peer Review

Internal Peer Review

Description of Method of Guideline Validation

The guideline was validated through two consultations.

1. The first draft of the guideline (the full guideline, National Institute for Health and Clinical Excellence [NICE] guideline, and Quick Reference Guide) were consulted with stakeholders and comments were considered by the Guideline Development Group (GDG).
2. The final consultation draft of the full guideline, the NICE guideline and the Information for the Public were submitted to stakeholders for final comments.

The final draft was submitted to the Guideline Review Panel for review prior to publication.

Evidence Supporting the Recommendations

Type of Evidence Supporting the Recommendations

The type of evidence supporting the recommendations is not specifically stated.

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

Appropriate management of identification and approach for consent in patients with the potential for organ donation for transplantation after brain-stem death (DBD) or cardiac death (DCD), to improve transplantation rates

Potential Harms

Although early identification is key and is expected to result in more donations (as procedures to preserve the viability of organs can be planned and made more timely), the guideline development group (GDG) was aware of the concerns of families and healthcare professionals that this may be perceived as denying the potential donor appropriate care. This is not the intention of the recommendation and therefore the use of clinical triggers and the decision to perform brainstem testing or withdraw life-sustaining treatments is used to define when potential donors should be identified.

Qualifying Statements

Qualifying Statements

- This guidance represents the view of the National Institute for Health and Clinical Excellence (NICE), which was arrived at after careful consideration of the evidence available. Healthcare professionals are expected to take it fully into account when exercising their clinical judgement. However, the guidance does not override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer, and informed by the summary of product characteristics of any drugs they are considering.
- Implementation of this guidance is the responsibility of local commissioners and/or providers. Commissioners and providers are reminded that it is their responsibility to implement the guidance, in their local context, in light of their duties to avoid unlawful discrimination and to

have regard to promoting equality of opportunity. Nothing in this guidance should be interpreted in a way that would be inconsistent with compliance with those duties.

Implementation of the Guideline

Description of Implementation Strategy

The National Institute for Health and Clinical Excellence (NICE) has developed tools to help organisations implement this guidance (see http://guidance.nice.org.uk/CG135 ; see also the Availability of Companion Documents field).

Implementation Tools

Clinical Algorithm

Foreign Language Translations

Patient Resources

Quick Reference Guides/Physician Guides

Resources

Slide Presentation

Staff Training/Competency Material

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

End of Life Care

IOM Domain

Effectiveness

Patient-centeredness

Timeliness

Identifying Information and Availability

Bibliographic Source(s)

National Institute for Health and Clinical Excellence (NICE). Organ donation for transplantation: improving donor identification and consent rates for deceased organ donation. London (UK): National Institute for Health and Clinical Excellence (NICE); 2011 Dec. 26 p. (Clinical

guideline; no. 135).

Adaptation

Not applicable: The guideline was not adapted from another source.

Date Released

2011 Dec

Guideline Developer(s)

National Institute for Health and Care Excellence (NICE) - National Government Agency [Non-U.S.]

Source(s) of Funding

National Institute for Health and Clinical Excellence

Guideline Committee

Guideline Development Group

Composition of Group That Authored the Guideline

Guideline Development Group (GDG) Members: Tim Collins, Intensive Care Unit Clinical Nurse Educator, Maidstone & Tunbridge Wells NHS Trust; James Fraser, Consultant in Paediatric Intensive Care, Bristol Royal Hospital for Children; Gary McVeigh (*Chair*), Professor of Cardiovascular Medicine, Queen's University Belfast; Karen Morgan, Regional Manager, Organ Donation and Transplantation, NHS Blood and Transplant, Watford; Paul Murphy, Consultant in Neuroanaesthesia and Critical Care, The Leeds Teaching Hospitals NHS Trust; Jane Nix, Patient and carer member; Ronan O'Carroll, Professor of Psychology, University of Stirling; Gurch Randhawa, Professor of Diversity in Public Health and Director, University of Bedfordshire, Bedford; Angus Vincent, Consultant in Intensive Care Medicine and Anaesthesia, Newcastle upon Tyne Hospitals NHS Foundation Trust; Huw Twamley, Consultant in Critical Care and Anaesthesia, Lancashire Teaching Hospitals NHS Foundation Trust, Preston; Barry Williams, Patient and carer member

Financial Disclosures/Conflicts of Interest

For the declarations of interests of all the contributors to this guideline, see Section 8.6 in the full version of the original guideline.

Guideline Status

This is the current release of the guideline.

Guideline Availability

Electronic copies: Available in Portable Document Format (PDF) from the National Institute for Health and Clinical Excellence (NICE) Web site .

Availability of Companion Documents

The following are available:

- Organ donation for transplantation. Improving donor identification and consent rates for deceased organ donation. Quick reference guide. London (UK): National Institute for Health and Clinical Excellence; 2011 Dec. 12 p. Electronic copies: Available in Portable Document Format (PDF) from the National Institute for Health and Clinical Excellence (NICE) Web site .
- Organ donation for transplantation. Improving donor identification and consent rates for deceased organ donation. Full guideline. London (UK): National Institute for Health and Clinical Excellence; 2011 Dec. 20 p. Electronic copies: Available in PDF from the NICE Web site .
- Organ donation for transplantation. Improving donor identification and consent rates for deceased organ donation. Appendices. London (UK): National Institute for Health and Clinical Excellence; 2011 Dec. Various p. Electronic copies: Available in PDF from the NICE Web site .
- NICE pathways. Organ donation for transplantation overview. Electronic copies: Available from the NICE Web site .
- Organ donation for transplantation. Costing report. London (UK): National Institute for Health and Clinical Excellence; 2011 Dec. 32 p. Electronic copies: Available in PDF from the NICE Web site .
- Organ donation for transplantation. Costing template. London (UK): National Institute for Health and Clinical Excellence; 2011 Dec. Electronic copies: Available from the NICE Web site .
- Organ donation. Baseline assessment tool. London (UK): National Institute for Health and Clinical Excellence; 2011. Electronic copies: Available from the NICE Web site .
- Organ donation. Slide set. London (UK): National Institute for Health and Clinical Excellence; 2011 Dec. 26 p. Electronic copies: Available from the NICE Web site .
- Organ donation. Clinical case scenarios for improving donor identification and consent rates for deceased organ donation. London (UK): National Institute for Health and Clinical Excellence; 2012 Apr. 49 p. Electronic copies: Available in PDF from the NICE Web site .
- Organ donation. Clinical case scenarios. Slide set. London (UK): National Institute for Health and Clinical Excellence; 2012 Apr. 72 p. Electronic copies: Available from the NICE Web site .
- Organ donation: educational resource: clinical triggers poster. London (UK): National Institute for Health and Clinical Excellence; 2012 Apr. 1 p. Electronic copies: Available from the NICE Web site .
- The guidelines manual 2009. London (UK): National Institute for Health and Clinical Excellence (NICE); 2009 Jan. Electronic copies: Available in PDF from the NICE Archive Web site .

Patient Resources

The following is available:

- Improving identification and consent rates for organ donation. Understanding NICE guidance. Information for people who use NHS services. London (UK): National Institute for Health and Clinical Excellence (NICE); 2011 Dec. 8 p. Electronic copies: Available in Portable Document Format (PDF) from the National Institute for Health and Clinical Excellence (NICE) Web site . Also available in Welsh from the NICE Web site .

Please note: This patient information is intended to provide health professionals with information to share with their patients to help them better understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical advice for particular patients. Rather we urge patients and their representatives to review this material and then to consult with a licensed health professional for evaluation of treatment options suitable for them as well as for diagnosis and answers to their personal medical questions. This patient information has been derived and prepared from a guideline for health care professionals included on NGC by the authors or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.

NGC Status

This NGC summary was completed by ECRI Institute on June 22, 2012.

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